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July 27, 2015

Via First Class and Electronic Mail
Kathleen C. Hittner, M.D.
Health Insurance Commissioner
Office of Health Insurance Commissioner
1511 Pontiac Avenue, Bldg. 69, Floor 1
Cranston, RI 02920

***Re: Blue Cross & Blue Shield of Rhode Island Rates Filed for 2016 Individual Market Plans OHIC*-2015.1**

Dear Commissioner Hittner:

I have enclosed the Report and Recommendation relating to the 2016 Direct Pay Rate Filing by Blue Cross & Blue Shield of Rhode Island.

Thank you for your attention to this matter.

Sincerely,

Raymond A. Marcaccio

RAM/nh
Enclosure
C: *w/enclosure*
Herbert W. Olson, Esquire
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Malena Lopez-Mora, Esquire

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
OFFICE OF THE HEALTH INSURANCE COMMISSIONER

IN RE:	**BLUE CROSS BLUE SHIELD OF**	:	
	RHODE ISLAND RATES FILED FOR	:	**OHIC-2015-1**
	2016 INDIVIDUAL MARKET PLANS	:	

REPORT AND RECOMMENDATION

I. INTRODUCTION

This Report and Recommendation is submitted to Commissioner Kathleen C. Hittner, M.D., Office of Health Insurance Commissioner (hereinafter "OHIC"), in connection with the Rate Request filed on May 15, 2015, as subsequently amended, by Blue Cross Blue Shield of Rhode Island (hereinafter "Blue Cross"). The Rate Request seeks approval of rates for plans offered to subscribers in the individual or Direct Pay market ("Filing"). The Filing originally sought an increase of 17.9 percent in the Essential Health Benefit ("EHB") rate.[1] As discussed more fully below, that rate request was modified to an 18 percent increase and later modified again to the current request for a 14.2 percent increase to the EHB rate.

II. THE HEARING

A. Jurisdiction

The Office of the Health Insurance Commissioner has jurisdiction in this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6. The

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[1] The EHB Base rate is defined as "the premium rate for the rating period for a plan providing all Essential Health Benefits required under the Affordable Care Act, adjusted to age 21 and to the expected utilization of a Silver benefits level plan with an actuarial value of .70. The EHB Base Rate assumes no cost sharing. It is therefore not a rate that corresponds to any one plan of benefits, but it is required to be developed in the rating process in order to provide a comparable process among plans. Actual base premium rates for each filed plan of benefits are found by multiplying the EHB Base Rate by the Plan Relativity Factors in Tab III of the OHIC Rate Review Template. The plan-specific base rates are then multiplied by the age factors to determine rates for each individual member." OHIC Ex. 1 at 3, n. 1.

hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*

B. Hearing Officer

The Health Insurance Commissioner appointed Raymond A. Marcaccio, Esq. as her designee ("Hearing Officer") to conduct this hearing pursuant to R.I. Gen. Laws § 27-19-6(c) and (d).[2]

C. Notice of the Hearing

Pursuant to a Scheduling Order entered on April 27, 2015, as amended on April 28 and May 15, 2015, this matter was scheduled for an evidentiary hearing ("rate hearing") on July 7 and July 8, 2015. Likewise, the public was invited to appear before me to provide comments concerning the Rate Request on July 7 and July 8, 2015. The Filing was advertised in accordance with applicable law and with the aforesaid Order, as amended, in a newspaper of general circulation, the *Providence Journal*, on June 24, 2015. The notice of the public hearing was also provided to all Blue Cross subscribers who are subject to the proposed rate increase. The notice was delivered by mail to those subscribers between June 19 and June 24, 2015, pursuant to R.I. Gen. Laws § 27-19-6(a) and § 27-20-6(a).

D. Pre-Filed Reports, Exhibits and Witnesses

In accordance with the Scheduling Order, as amended, the Attorney General and OHIC conducted pre-hearing discovery to examine the basis for the Rate Request. The Attorney

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[2] The term "designee" as used in this section:

> shall mean a person who is impartial, a member in good standing of the Rhode Island bar and a person who is sufficiently acquainted with the rules of evidence as used in the superior court of the state so as to enable that person to conduct a hearing as designee of the commissioner.

R.I. Gen. Laws § 27-19-6(d). In that capacity, I can recommend to the Commissioner that the proposed rates be approved, disapproved or modified. R.I. Gen. Laws § 27-19-6(c).

General submitted discovery in the form of data requests on May 20, June 1, June 2, June 5, June 8 and June 10, 2015. OHIC likewise propounded data requests on May 22, June 1, June 4, June 11 and June 19, 2015.

Conferences and hearings were conducted prior to the rate hearing in order to address various issues that arose prior to the hearing dates. On June 9, 2015, a conference was conducted to address a Motion for a Protective Order filed by Blue Cross. Blue Cross requested that certain Board of Directors' minutes be disclosed exclusively to counsel for the Attorney General and OHIC. After hearing, I ordered that the minutes be disclosed to the parties' actuarial expert witnesses so that they could better assess the merits of the Filing.

Thereafter, on June 29, 2015, the Attorney General filed an Emergency Motion to Extend Time to File Alternative Calculations. The basis for the Attorney General's motion was the anticipated Motion to Intervene by Neighborhood Health Plan of Rhode Island ("Neighborhood Health") which, if allowed, would require additional discovery and/or calculations, depending on whether the original or amended Filing was the subject of the hearing. I denied the motion on the grounds that it was premature. However, immediately thereafter, Neighborhood Health filed its Motion to Intervene for the purpose of objecting to the Blue Cross modified Rate Filing of June 1, 2015. That matter was the subject of an initial hearing *via* telephone and a subsequent hearing for oral argument on July 1, 2015. After lengthy argument, I denied the motion for the reasons set forth in my Order of July 2, 2015. In summary, I found that Neighborhood Health had not met the criteria for intervention as a party and, further, that the public interest was adequately represented by the Attorney General and OHIC.

With only one exception, each of the exhibits were introduced as full exhibits by agreement of the parties. The exhibits largely consisted of reports and analyses prepared by the actuarial experts, including Blue Cross Exhibit 1, which is the Direct Pay Rate Filing submitted to OHIC on May 15, 2015, as amended on June 1, 2015, and introduced and certified by Jeffrey McLane, FSA, MAAA. Blue Cross also submitted Exhibit 2, an affidavit certifying that it provided notice of the proposed rate increase to the public and Blue Cross subscribers pursuant to R.I. Gen. Laws §§ 27-19-6(a) and 27-20-6(a). Blue Cross Exhibit 3 is a modification to its rate filings dated June 26, 2015, consisting of a revised OHIC template. Finally, with respect to Exhibit 4, which consisted of a graph demonstrating data from the 2014 rate year, I ruled that the exhibit could be introduced in full, after considering the Attorney General's objection.

The Attorney General likewise submitted exhibits, primarily consisting of a report prepared by the actuarial expert, Barbara P. Niehus, FSA, MAAA, along with her schedules supporting her calculations, AG Ex. A, with attachments AGBN-1 through AGBN-13; AG Exhibits B through AG-AR; and AG-AS, which consisted of Ms. Niehus' supplement to her report dated June 29, 2015. OHIC submitted the actuarial analysis of Charles C. DeWeese, FSA, MAAA as well as their supporting Exhibits 2 – 46. At the hearing, OHIC also introduced for identification Exhibit 47, an OHIC bulletin entitled "Renewal and Discontinuance of the Plans in the Individual and Small Group Markets."

During the rate hearing, the parties stipulated that OHIC Exhibits 14, 30 and 38 set forth proprietary information concerning Blue Cross business. Those three exhibits are sealed. Tr. I at 211.

Blue Cross presented testimony from its actuary, Mr. McLane, as well as Ms. Elaine Alderdice, Director of Cost Accounting and Budgets. The Attorney General presented testimony from the actuary, Ms. Niehus, as well as testimony from Augustin Manocchia, M.D., Chief Medical Officer and Senior Vice President for Clinical Affairs at Blue Cross, and Tonya Hoegen, Market Segment Manager for the Individual Market at Blue Cross. OHIC introduced testimony from its actuary, Mr. DeWeese.

E. Public Comment

The public submitted comments on the proposed rate increase both in person at the rate hearing as well as through correspondence. Each submission was strongly opposed to the Blue Cross request for a rate increase. Each person who appeared before me expressed dire concern with the significant increase in health insurance costs, year over year. Some people expressed concern that they have seen none of the financial relief that was anticipated with the passage of the Patient Protection and Affordable Care Act ("ACA"). Other people stated that the increase in premiums has required them to purchase plans with very high deductibles. Ironically, they are now visiting their doctors less frequently due to the very high deductibles. It should be noted that Blue Cross had customer service representatives available at the rate hearing to address any questions from subscribers and other members of the public.

III. STANDARD OF REVIEW

This hearing is governed by the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.* ("APA"). Pursuant to the APA, the rules of evidence used in civil court proceedings were followed. R.I. Gen. Laws § 42-35-10.

This Report and Recommendation addresses the reasonableness of the requested rate increase. I am guided by the legislative mandate that requires Blue Cross to provide "affordable and accessible health insurance ," R.I. Gen. Laws § 27-19.2-3(1), for a "comprehensive range of consumers, including business owners, employees and unemployed individuals." R.I. Gen. Laws § 27-19.2-3(5). There is likewise an important but competing statutory mandate to ensure that Blue Cross remains financially sound. R.I. Gen. Laws § 42-14.5-2.

The moving party must meet the burden of proving, by a preponderance of the evidence that "the fact to be proved is more probable than not." *Miele v. Bd. of Med. Licensure and Discipline*, 1991 WL 789899 (R.I. Super. Ct. 1999). Thus, Blue Cross has the burden of proving by a preponderance of the evidence that the Filing is consistent with both its conduct of business and meeting the interests of the public in providing affordable health insurance plans. *Blue Cross & Blue Shield of R.I. V. McConaghy,* 2005 WL 1633707 (R.I. Super. Ct. 2005).

The Filing must also meet the requirements imposed by the ACA. The Filing must comply with all requirements imposed by the ACA which imposes a number of restrictions on the setting of rates, including anti-discriminatory practices and rates that vary by gender or by health status.

IV. DISCUSSION

A. The May 15, 2015 Filing

Blue Cross submitted its initial Filing for individual or Direct Pay health insurance products on May 15, 2015. BC Ex. 1. Thereafter, on June 1, 2015, Blue Cross submitted a revised Filing to address its modifications to one of its plans, the BlueCHiP Advanced Plan – removing it from the tiered network while maintaining a referral model. BC Ex. 1 at BC114. These modifications resulted in a slight increase to the EHB rate from 17.9 percent to 18 percent. BC Ex. 1 at BC040.

Further modifications were submitted by Blue Cross on June 26, 2015, to address new information from OHIC and the General Assembly. First, the Blue Cross Filing included a commissions charge for its anticipated use of brokers in 2016. However, on June 24, 2015, OHIC issued a memorandum informing carriers that "it does not intend to approve broker commissions in the individual market for plans effective January 1, 2016. OHIC will re-evaluate this decision during the 2016 Rate Review Process for plans effective January 1, 2017." OHIC Ex. 7a; Tr. I at 31. Blue Cross removed the payment of commissions to brokers from its Filing. Tr. I at 31. Likewise, the initial Filing included the calculation of a HealthSource RI ("HSRI") exchange fee at 4.7 percent of premium. BC Ex. 1 at BC094. However, the General Assembly later passed a budget that included a lower HSRI exchange fee of 3.5 percent. Tr. I at 29. Moreover, the fee is now to be distributed across all of Blue Cross' Individual Market members, not only those who obtained coverage from HSRI, resulting in an effective charge of 2.6 percent of premium. Tr. I at 29. Consequently, Blue Cross modified its Filing to reflect these changes, resulting in a weighted average rate increase from 11 percent to 7.3 percent and a reduction in the EHB rate increase from 18 percent to 14.2 percent. BC Ex. 3; Tr. I at 32.

The actuaries for OHIC and the Attorney General agree with many assumptions and components of the Blue Cross filing. There is no challenge to Blue Cross' methodology for the development of its proposed individual rates. OHIC Ex. 1 at 4. The general methodology used by Blue Cross is consistent with the instructions provided by OHIC. *Id.* Thus, most of the Filing, as modified, is not in contention. The challenges posed by the Attorney General and OHIC are in the following categories:

Lag Adjustment Factor

In-Patient Hospital Utilization Trend

Hospital Cost Trend: ICD-10 Implementation

Hospital Out-Patient Utilization Trend

Professional Services Utilization Trend

Pharmacy

Calculation of Federal Reinsurance Credit

Uncollected Premium Adjustment

Contribution to Reserves and Impact of Federal Subsidies

Each of these factors and adjustments are now discussed.

Lag Adjustment Factor

Blue Cross introduced a new adjustment in this year's Filing, which it described as a "Lag Adjustment Factor." Blue Cross explained that 2014 was the first year of implementation of the ACA reforms, resulting in a substantial increase in participation in the individual or Direct Pay market. Tr. I at 69; Tr. II at 122-123. The health insurance exchange had an open enrollment period from October 1, 2013 through March 31, 2014, with effective dates of coverage beginning between January and May of 2014. Blue Cross observed that 45 percent of its individual market membership "consisted of new Exchange enrollees that joined between these five months." BC Ex. 1 at BC043. Thus, new members made up more than half of the direct market for 2014, with a growth in subscriptions from 14 or 15,000 to approximately 35,000. Tr. I at 72. The new members were being introduced to the experience of having health insurance. Tr. I at 34. It was only after the first few months that this population started to utilize health insurance benefits. Tr. I at 69. Mr. McLane concluded that the first two months were "artificially low," with a PMPM of \$363.00, versus an overall PMPM of \$430.00.[3] Tr. I at 35. From March through December, the new members experienced an almost identical utilization as the existing members, with new members' PMPM at \$431.06 and the existing members at \$430.77, or approximately a \$0.30 difference. Tr. I at 96. Mr. McLane concluded that it would be appropriate to exclude the first two months of data to compensate for this lag factor.

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[3] PMPM stands for "per member per month" and means the average monthly measurement unit for a member in a given cohort or group.

The Attorney General and OHIC contend that the lag factor is not an appropriate adjustment. The Attorney General explained that Blue Cross' exclusion of the more favorable experience from the first two months puts undue weight on the less favorable experience in the remaining months for the 2014 enrollees. AG Ex. A at 6-7; Tr. I at 224-225. Ms. Niehus likewise recognized a cycle to the utilization of services. First, there is an initial learning curve and admitted lag in services caused by the time needed to schedule appointments and become acquainted with health insurance benefits. This is followed by a "catch up" period for the use of increased services and then a downward trend to a more reasonable level experience near the end of the year. While Ms. Niehus is generally familiar with the lag factor phenomenon, she has never seen it used before to exclude the more favorable months, thereby emphasizing the less favorable experience when establishing the 2016 rates. Tr. I at 225.

Ms. Niehus further explains that the observed discrepancy in utilization was due to a population for 2014 that was healthier than Blue Cross anticipated. Blue Cross has always provided access to insurance for those who could not pass underwriting. Tr. II at 152. Consequently, "the barrier to coverage was not underwriting, the barrier to coverage was affordability." Tr. II at 152. Ms. Niehus testified that the number of claims for 2014 bears out this premise. Tr. II at 152. (Consistent with Ms. Niehus' observations, Mr. McLane testified that the 2014 rate year experienced "much lower claims than we expected." Tr. I at 34.)

Mr. DeWeese supports Ms. Niehus' observations and notes that it is more reasonable to assume that people merely postponed care during the first two months and that the care was actually going to be received later in the same calendar year. Therefore, there would be no actuarial reason to remove the first two months of claims data. Tr. II at 178. Likewise, Mr. DeWeese observed that the 2014 population was healthier than anticipated. Finally, Mr.

DeWeese performs numerous rate reviews for the Commonwealth of Massachusetts. Consistent with Ms. Niehus, Mr. DeWeese has never seen the lag factor used to justify the removal of entire months of claims data. Tr. II at 179.

I find that the weight is considerably in favor of utilizing the claims data from all 12 months of 2014, rather than artificially excluding the first two months. It is customary to use every month of claims data when projecting future claims. Apparently, no other carrier employs this factor to exclude relevant data. Tr. I at 179. Blue Cross has not persuaded me to digress from that standard actuarial practice. Simply because the data during the first two months of enrollment is better, it should not be excluded. I find it more likely that the new enrollees delayed care, rather than permanently deferred it. Care that is only postponed until later in the year leads me to conclude that the entire 12 months of 2014 claims data should be used to predict projected medical expenses.

According to the testimony of OHIC and the Attorney General, by removing Blue Cross' proposed lag factor adjustment, the EHB Rate increase will be reduced by either 1.5 percent or 1.6 percent.

In-Patient Hospital Utilization Trend

When making trend projections in this Filing, Blue Cross used a "linear least squares method" to project utilization/mix trend factors. The actuaries attempt to account for all variances in order to yield a statistical "best fit," measured by an R-squared valuation. The higher the R-squared value, the better the projected line "fits" the data. "An R-squared of under .7 is generally considered to not be useful at all, but the higher the R-squared, the better measure of fit it has." Tr. I at 49. Blue Cross calculated a negative 4.5 percent trend, with a very reliable R-squared value of .933 for its in-patient hospital utilization. That R-squared value is based upon all of its commercial business. There is an even more pronounced downward trend (negative 5.4 percent) when exclusively measuring the Direct Pay market, with an R-squared value of .702, which is still a reliable statistical measurement. Mr. McLane exercised actuarial judgment and proposed an in-patient hospital utilization trend rate of 0 percent, explaining that a negative 4.5 percent utilization trend simply is not sustainable in the long term. He also observed that the in-patient services actually increased near the end of 2014.

Ms. Niehus testified that it is "very reasonable" to expect to see a negative trend continue in 2016. Tr. I at 229. Her testimony is buttressed by the fact that Blue Cross has made significant efforts to reduce in-patient hospitalizations and re-admissions. Tr. I at 227, Tr. II at 132. She thus concludes that a negative 2 percent trend for in-patient hospital utilization is more reasonable and sustainable for the near future. Tr. I at 227. While there is an increase in the in-patient utilization trend near the end of the year, Ms. Niehus did not find that to be statistically significant since, in her opinion, the increase is reflected in only two points with a third point "pretty close to the line." Tr. II at 135.

Mr. DeWeese observed that Blue Cross has adhered to a long-standing methodology of analyzing cost trend, used again in the current filing, but that they have not adopted all of the results of that methodology for this trend factor. Tr. II at 170-171. Nonetheless, Mr. DeWeese agrees that actuarial judgment is appropriate, noting that the 4.5 percent negative trend is "too steep" a decrease to expect continue into the long-term future.[4]

I find that it is appropriate to exercise actuarial judgment for this factor and reduce the negative trend factor, as called for by each actuary who testified in these proceedings. The

[4] Admittedly, a rate of negative 4.5 percent is not sustainable in the long term, eventually leading to no use of in-patient services. However, to reach zero utilization would take 100 years at a negative 4.5 percent trend, according to Mr. DeWeese. Tr. II at 207.

question thus becomes whether I should adopt a negative 2 percent trend – proffered by Ms. Niehus and Mr. DeWeese – or the flat trend (0 percent) proposed by Mr. McLane. Admittedly, the most recent data points turn positive. However, only two data points are positive. There is far more data that moves in a decidedly downward direction.

In my opinion, Mr. McLane's projection of 0 percent departs too far from the trend observed from these data points. The projected decrease proffered by Ms. Niehus and Mr. DeWeese more closely follows the trend measured over the last 12 months, which yields a negative 1.9 percent trend. BC Ex. 1 at BC045. Moreover, given the testimony of Dr. Manocchia, and the continued efforts of initiatives undertaken by Blue Cross, it is appropriate to anticipate a continued negative trend. *Id.* at 172. Thus, I find that a negative 2 percent trend is more appropriate and I recommend its adoption. A reduction of the in-patient hospital utilization trend from 0 percent to negative 2 percent should result in a 0.8 percent or 0.9 percent decrease to the proposed EHB rate. AG Ex. A, AGBN-5; AG Ex. AS at 1; Tr. I at 216-228; OHIC Ex. 9.

Hospital Cost Trend: ICD-10 Implementation

One component of hospital cost trend is the anticipated conversion to a new method of classifying diagnoses and procedures at hospitals within the claim system. Tr. I at 102. Presently, hospitals classify diagnoses under the ninth version of the International Classification of Diseases (ICD-9-CM). The tenth version (ICD-10) will "greatly broaden the number of classifications available for a doctor to submit a claim within a given diagnosis." Tr. I at 102. The transition from ICD-9 to ICD-10 was first scheduled to occur on October 1, 2013. That transition was delayed. Even now, there is no certainty as to its implementation date. However, each party testified that the transition will likely occur in October of this year.

Blue Cross attributes a 1 percent increase to its in-patient hospital costs, commencing in October of 2015, as a result of the new coding system. Blue Cross hired an outside consultant to assess the impact of the coding system conversion. Dr. Manocchia testified that some claims will see a significant increase in costs, specifically related to its implementation. For example, with respect to the diagnosis of septicemia, the outside consultant reported that this diagnosis alone could result in an increase of costs from $29,000 to $60,000. Tr. II at 87. A number of codes when submitted under ICD-10 will "generate claims for the same care that are substantially higher than what was generated in ICD-9." Tr. II at 86. Based upon the consultant's report, Blue Cross expects to see claims increase in costs by 1 to 1.5 percent as a direct result of the anticipated conversion. Tr. II at 81.

The Attorney General and OHIC do not support the requested rate increase for this category. They both point to a report from the Centers for Medicare & Medicaid Services ("CMS") that currently predicts that the transition "will have a minimum impact on aggregate payments to hospitals." *See* AG Ex. AG-AN, Medicare & Medicaid Research Review, 2011: Vol. 2, Number 2. Likewise, as Mr. DeWeese testified, Blue Cross can negotiate with providers if the coding conversion results in increased payment levels. Tr. II at 181. Further, in Mr. DeWeese' view, the onus for that mitigation should be borne by Blue Cross and the risk for that conversion should not be assumed by Direct Pay consumers. Tr. II at 181.

I am not persuaded that the proposed increase is justified. It should be noted that the report referenced by Dr. Manocchia was not introduced into evidence and even Dr. Manocchia could not explain in detail what would account for the increases. Given that CMS currently predicts a neutral impact in costs, and given the absence of evidence by Blue Cross to support its proposed increase, I find this aspect of the projected trend increase to be too speculative to support. The proposed increase to rates should be removed from the 2016 rate increase. Based upon the testimony, I anticipate that that the EHB rate increase will be reduced by 0.2 percent. OHIC Ex. 9.

Hospital Out-Patient Utilization Trend

When calculating the hospital out-patient utilization trend, Blue Cross initially measured data from all three of its commercial markets: Direct Pay, Small Group and Large Group. This generated a "best fit" line of 1.9 percent. However, Mr. McLane testified that the trend observed in the Small Group market was "abnormal" from the other two markets and therefore needed to be discounted. Tr. I at 144-145. He reduced the weight of the Small Group market by 50 percent when factoring in the results of each of the commercial business segments. In doing so, Blue Cross reached a positive 2.3 percent trend for the out-patient utilization, instead of the best fit of 1.9 percent. BC Ex. 1 at BC045; Tr. I at 52-53.

I do not find sufficient evidence to justify Blue Cross' rejection of its own data. For each of the past three years, Blue Cross had projected this trend by measuring data from all three of its commercial markets. Simply because Blue Cross cannot immediately explain why the Small Group market yields a different trend, it is not a sufficient reason to diverge from its own standard methodology. As such, I recommend that the trend observed for all three markets, 1.9 percent, be used to project the hospital out-patient utilization. This will reduce the EHB base rate increase by approximately 0.2 percent.

Professional Services Utilization Trend

The professional services utilization trend measures the combined data for medical/surgical and primary care. Blue Cross' own methodology yielded a negative 1.6 percent trend for the entire commercial market with a very reliable .85 R-squared value. Tr. 1 at 231. Despite finding this negative trend, Blue Cross rejected its own methodology and calculations. Instead, Blue Cross adjusted its trend to a neutral 0 percent because it observed a positive utilization trend rate in 2014. Tr. I at 53. Mr. DeWeese likewise observed that the Blue Cross data on all three business segments developed a least square "best" fitted line of negative 1.6 percent. Nonetheless, Mr. DeWeese supported Mr. McLane's actuarial judgment of a zero percent trend since the data over the past 6 – 12 months was much flatter. Tr. II at 175.

Ms. Niehus testified that a more appropriate trend factor would be negative 1 percent. Tr. I at 231. In Ms. Niehus' view, the concerted efforts by Blue Cross to emphasize the role of the primary care physician should continue to put downward pressure on the use of specialists and other professional services. Tr. I at 231; *see also* McLane testimony, Tr. I at 146. As Ms. Niehus explained, the Direct Pay premium includes monies that pay for the initiatives to emphasize the role of the primary care physician and, therefore, the members of Direct Pay "should get the benefit of the expected reduction in the use of the specialist services." Tr. I at 231-232. Consequently, Ms. Niehus proposes that a utilization trend of negative 1 percent be adopted, rather than the neutral (0 percent) trend proposed by Blue Cross.

I am persuaded by the statistical evidence, demonstrating a "best fit" value of negative 1.6 percent, which is based upon an R-squared value of .85, which is very reliable. If any departure is warranted, as each party has suggested, I find that the most appropriate departure would recognize a negative trend, consistent with most of the statistical data. I therefore find that this category should utilize a negative 1 percent trend factor, consistent with the recommendation of the Attorney General. This is expected to reduce the proposed EHB rate increase by 0.5 percent. AG Ex. A at 10, Attachment AGBN-7, AG Ex. AS at 2; Tr. I at 231-232.

Pharmacy

The Blue Cross filing included a 9.5 percent trend factor for pharmacy. OHIC withdrew its opposition based upon the testimony at the hearing, now finding it to be reasonable due to the recent experience of significant increases in specialty drugs, including Solvaldi, which treats hepatitis at a cost of $100,000 for a three-month treatment. Tr. I at 57; Tr. II at 176. I am equally persuaded by the statistical evidence, which demonstrates a best fit trend line that establishes the 9.5 percent trend increase. BC Ex. 1 at BC045; Tr. I at 55-56, 57.

Calculating Federal Transitional Reinsurance Credit

When projecting its 2016 claim costs, Blue Cross calculated a credit against claims attributable to the Federal Transitional Reinsurance program. Tr. I at 238. To reach its projection, Blue Cross applied trend factors for cost increases but did not apply any assumed increase for utilization. Mr. McLane testified that a utilization factor was not included since these members are already "high utilizers." Tr. I at 108. Since the population is already using extensive services, Mr. McLane does not believe that this population will experience any increased utilization. *Id.*

In contrast to the Blue Cross assumptions, Ms. Niehus explains that even large claims can experience increased utilization. *Id.* Thus, in Ms. Niehus' opinion, Blue Cross should have used the same cost/utilization trend rate for large claims that it uses for the remainder of its Filing. Tr. I at 239. The Attorney General calculated an annual trend of 4.63 percent, by including each of the trend factors used by Blue Cross for the remainder of its Filing. Tr. I at 239-240; AG Ex. A, Attachment AGBN-11.

I find that Blue Cross has not met its burden to establish why it should exclude utilization trends when calculating a credit against claims under the Federal Transitional Reinsurance program. No evidence was presented to prove that members with very high claims experience a significantly lower utilization, when compared to the remaining members. It is possible that members who have very high claims could experience an increase in utilization, for example as a medical condition worsens. I conclude that Blue Cross should apply the same trend factors – including utilization – when calculating projected federal reinsurance credits. I anticipate that this will reduce the increase in the 2016 EHB rate by 0.2 percent.

Uncollected Premium Adjustment

The Blue Cross Filing includes an adjustment for uncollected premiums that occurred in 2014. BC Ex. 1 at BC047. The ACA requires the carrier to pay claims for a member who does not make payment on his premiums for a one month "grace period." 45 C.F.R. § 156.270(d)(1). The ACA requirement is similar to a requirement imposed upon Blue Cross in previous years. Mr. McLane testified that "Blue Cross is required to cover a member for one month after they stop paying their claims. [Blue Cross] cannot deny any of the claims during that period. ....[even though Blue Cross has] not received the premium for that [month]." Tr. I at 104. While Blue Cross has historically made such payments for this "grace period," there are now many more members in the Direct Pay market, thus having more of an impact on premiums. *Id.* at 104. Blue Cross proposes an increase of 0.9 percent of its required premium for 2016 in anticipation of uncollected premiums for 2016.

OHIC has no opposition to the requested adjustment. The Attorney General does challenge the grace period adjustment, based upon the data that it received from Blue Cross in preparation for the rate hearing. That data led the Attorney General to assume that Blue Cross did not count the grace period months in its 2014 experience. Tr. I at 142. However, Blue Cross has testified that it did indeed include the grace period months in the 2014 experience and that the grace period months were used to project its rates for 2016. Tr. I at 181. Moreover, Blue Cross testified that where it received a federal subsidy during the grace period, it did not include the amount of that subsidy in its calculation. Tr. I at 105. Its calculation of uncollected premiums included only the amounts that were due from members during the grace period months. *Id.*

It is appropriate to distribute the experience of losing the revenues for the grace period months to the rates charged to the other members. Tr. I at 105-107. The Attorney General's challenge was initially based upon incorrect data that it received from Blue Cross during the discovery phase of this proceeding. In response to Data Request 2-04, Blue Cross incorrectly answered questions that reasonably led Ms. Niehus to conclude that the carrier was not counting the grace period month in its 2014 experience. Tr. I at 142. I am persuaded that Blue Cross is entitled to the adjustment requested for this factor. Since Blue Cross made payment of claims during the grace period, it is appropriate to distribute that lost premium to all of its members when projecting its rates for 2016.[5] I recommend the proposed increase of 0.9 percent in anticipation of uncollected premiums for 2016.

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[5] The Attorney General does not assert that Blue Cross intentionally failed to provide accurate data. In fact, I have found that each of the parties engaged in good faith in both the conducting of discovery and the presentation of evidence at the rate hearing. I think it is worthwhile to comment on the level of professionalism and competency that I observed from both legal counsel and witnesses who participated in these proceedings. It is remarkable that the parties have engaged in such rapid and thorough discovery on such an accelerated schedule.

Contribution to Reserves and Impact of Federal Subsidies

Blue Cross requests a 3 percent contribution to its capital reserves with this Filing. BC Ex. 1 at BC 049; Tr. I at 49. The contribution consists of a 2 percent contribution to reserves, .34 percent for the costs associated with a new claims processing system, and .5 percent to pay for any federal taxes on the reserve contribution, for a total of 2.84 percent. Blue Cross rounds this figure up to a 3 percent contribution. BC Ex. 1 at BC 049; AG Ex. AM at 16-17; OHIC Ex. 28.

In support of this request, Blue Cross argues that it must build up its reserves in order to fortify its financial stability. Tr. I at 43; Tr. II at 118-119. Blue Cross also references the fact that the percentage of the reserves sought from the Direct Pay market are lower than the percentage sought from the remainder of the commercial market. Tr. I at 111.

There are two measurements that can be used to quantify capital reserves: a percentage of revenues or risk based capital ("RBC"). Tr. I at 42. The Blue Cross Association requires a certain level of capital reserves, and monitors any Blue Cross entity that falls below 375 percent of RBC. If capital reserves fall below 200 percent of RBC, the entity is removed from the Blue Cross Association. *Id.* at 44. Mr. McLane noted that the capital reserves for Blue Cross are inadequate under either measure. With respect to the RBC analysis, Mr. McLane warned that if Blue Cross lost $45 million, it would be within 375 percent of RBC. Tr. I at 44. Blue Cross could sustain such a loss in a single rate year. For example, Blue Cross sustained a $42 million loss in 2012. Tr. I at 45. Therefore, Blue Cross could lose adequate reserves in a single rate year. *Id.* Mr. McLane also noted that Blue Cross reserves are the third lowest in the national association of Blue Cross membership. Tr. I at 48. With respect to the percentage of revenue, Mr. McLane referred to the Lewin Report, which was commissioned by OHIC. The Lewin

Report recommended that Blue Cross maintain capital reserves between 23-31 percent of its revenue. *Id.* at 46. Presently, Blue Cross capital reserves are 16.1 percent of revenue. *Id.*

Blue Cross points out that the 16.1 percent of revenue, with a risk based capital ratio of 466 percent, represents the lowest reserve values since 2010. OHIC Ex. 1 at 12; OHIC Ex. 6a. Its reserves have been below the Lewin recommended standard for at least the past five years. OHIC Ex. 6a; Tr. II at 191. Blue Cross' reserves fell nearly $25 million from the end of 2014 to the end of the first quarter of 2015. OHIC Ex. 6a. Likewise, Blue Cross has lost nearly $18 million in the Direct Pay market between 2010 and 2013. Tr. I at 36-37. In order to meet its claims, Blue Cross was required to utilize its reserves. Tr. I at 41; Tr. II at 122, 212. Thus, Blue Cross concludes that it is both appropriate and indeed necessary to make the 3 percent contribution to capital reserves in order to maintain financial stability.

The request for a 3 percent contribution to reserves must be viewed in conjunction with the significant gains made by Blue Cross in the Direct Pay market for 2014, totaling approximately $16 million. These gains can be broken down into three sources: (1) approximately $10 million from the Federal Transitional Reinsurance program; (2) approximately $577,730 from the Federal Risk Adjustment program; and (3) approximately $6 million from surplus generated from the 2014 Direct Pay premiums. Each of these components is now discussed in further detail.

The Federal Transitional Reinsurance program was established under the ACA in order to stabilize premiums for coverage in the individual market during the years 2014 through 2016. Under Section 1341(b)(2) of the ACA, reinsurance payments are to be made to carriers for high-risk individuals in order to provide for the equitable allocation of funds. Since the program is set to expire at the end of 2016, carriers such as Blue Cross will not have the benefit of these reimbursements in future years.

The program is designed to reimburse for a portion of a subscriber's claims that exceed a "threshold dollar amount for claims costs incurred by a health insurance issuer for an enrolled individual(s) covered benefits in a benefit year," which is referred to as the "attachment point." 45 C.F.R. § 153.20. The federal government made two modifications to this reimbursement program that resulted in additional, unexpected monies to Blue Cross for the 2014 Direct Pay rate year. First, in 2015, the government modified the threshold dollar amount, or attachment point, from $70,000 to $45,000. This modification resulted in the receipt of an additional $4.9 million for Blue Cross. Since this adjustment was made prior to the submission of its Filing, Blue Cross has already factored in this federal subsidy. Neither OHIC nor the Attorney General seek any reduction to either reserves or the proposed 2016 rates for this portion of the federal subsidy. Tr. I at 241; Tr. II at 186.

A second modification by the federal government was made in June of 2015. It increased the percentage of reimbursement to carriers, from 80 percent to a full 100 percent on claims paid between $45,000 and $250,000. Tr. I at 34-36. This translates to an additional $4.7 million for Blue Cross that was unanticipated for the 2014 rate year.

An additional unexpected subsidy resulted from the Federal Risk Adjustment program, which will likely result in the receipt of approximately $577,730. Tr. I at 40, 130-131; OHIC Ex. 46 at 36. Blue Cross just learned of this unexpected subsidy in late June of this year. The government determined that Blue Cross' actuarial risk was greater than that of its market competitor, Neighborhood Health, for the 2014 rate year. The federal government is redistributing this risk by providing essentially a payment from Neighborhood Health to Blue

Cross in the amount of $577,730. Thus, the federal subsidies at issue amount to a total of approximately $5,277,730.

The remaining component of the gain is from the 2014 premiums that exceed costs by approximately $6 million.

I am confronted with three possibilities when determining how to allocate these monies: (1) permit Blue Cross to retain the entirety of these gains which would be added to its reserves; (2) reallocate some or all of these gains to lower the 2016 rates in the Direct Pay market by making a dollar-for-dollar adjustment to premiums; or (3) deny or reduce Blue Cross' request for 3 percent contribution to reserves, in recognition of the additional monies it unexpectedly received from the federal government for the 2014 rate year. This issue most visibly demonstrates the tension that exists between two competing statutory obligations of the Commissioner: to provide affordable health insurance to subscribers while also maintaining the financial viability of Blue Cross.

Blue Cross presents a cogent argument for retaining the unanticipated federal subsidies without any reduction to its request for a 3 percent contribution to reserves. It contends that the Transitional Reinsurance program, the Risk Insurance program and the Risk Corridor program are all designed to stabilize the individual and small group health insurance markets. When coupled with the medical loss ratio ("MLR") rebate program, insurers are not able to experience either excessive gains or losses in the individual market. The Transitional Reinsurance Program is designed to limit a carrier's risk in the individual market by offsetting a portion of the risk caused by high cost enrollees. The Risk Adjustment program redistributes risk amongst carriers by transferring funds from carriers with lower risk enrollees to carriers with higher risk enrollees.

The Risk Corridor program is designed to limit both profits and losses that a carrier could experience from rates set either too high or too low during the first three years of the implementation of the ACA. When a carrier's profits exceed 3 percent of a targeted amount, it must pay a portion of those proceeds back to the federal government. Similarly, losses that exceed 3 percent of a targeted amount result in a federal payment to offset a portion of those losses. Finally, with respect to the MLR rebate program, a carrier must provide a rebate to each of its members if its MLR in the individual market is less than 80 percent.

Blue Cross notes that the MLR rebate program looks at the insurer's performance in the Direct Pay market over the course of three years, rather than a single year. Likewise, the regulations relating to reinsurance payments and risk adjustment payments require such payments to be applied to 2014 for purposes of making the risk corridor calculation. If the MLR rebate program looked at only one year of financial performance, an insurer would be required to rebate premiums if it experienced large gains in one year but experiences significant losses in the two previous years. The rebate program is designed to ensure that gains realized over the *longer term* are assessed for a possible return to members. The gains from these federal subsidies in 2014 were not enough to require any redistribution of the profits under the mechanisms afforded in the ACA. Finally, as Mr. McLane testified, it would be "actuarially inappropriate to factor in past events [such as these additional federal subsidies] to the current rate filing." Tr. I at 58. It is not appropriate to transfer gains or losses from a previous year and move such factors into another rate filing as an offset. Tr. I at 58.

OHIC is opposed to permitting Blue Cross to add the unanticipated federal subsidies to its capital reserves. As Mr. DeWeese explained at the hearing, the most appropriate way to handle this unexpected "windfall" is to make a dollar-for-dollar adjustment to the 2016 rates. Tr.

II at 182, 184. In his view, this federal subsidy is intended to directly benefit consumers and was not expected by Blue Cross. Mr. DeWeese supports the application of the additional monies received from the Transitional Reinsurance program ($4.7 million) as well as the Risk Adjustment subsidy of approximately ($577,730) to be applied to directly reduce the 2016 rates for the Direct Pay market. As Mr. DeWeese concluded, "given that the nature of risk adjustment system is to create a level playing field and have the rates be level among carriers and not reflect who has got the better risks, those payments really should support rates and not just be put into reserves." Tr. II at 187-188. Finally, OHIC observed that a similar approach was taken in 2015 when Blue Cross learned of the modified attachment point for the Transitional Reinsurance program. As a result of that modification, Blue Cross amended its 2015 filing with a reduction to its rate increase from 12.3 percent to 9 percent to reflect the additional federal subsidies.

The Attorney General expresses similar concerns to that of OHIC, but has an alternative approach for dealing with the additional federal subsidies. The Attorney General recommends that the contribution to reserves be reduced from 3 percent to 1 percent. Tr. I at 240. In doing so, the additional federal subsidies would be added to reserves. In further support of her position, Ms. Niehus explained that reduced contributions are appropriate since Blue Cross is now preparing its projections based upon data generated since the full implementation of the ACA reforms. Therefore, there is more predictability that can be obtained from the members' history and, consequently, there should be less risk for Blue Cross when calculating premiums. AG Ex. A at 15; Tr. I at 241; Tr. II at 24. With less risk, the Attorney General concludes that there is less demand for larger amounts to be transferred to the capital contribution for the Direct Pay market. Ms. Niehus also challenges the Blue Cross concern with financial stability by describing Blue Cross' capital as compared to its risk based capital ("RBC") requirements as being comfortably above minimum levels for the last five years. In accordance with R.I. Gen. Laws § 27-4.7, as long as the ratio of capital and surplus to risk exceeds three times the authorized level of RBC, no further action is required by OHIC. At the end of 2014, the ratio was approximately 4.7. AG Ex. A at 14-15, n. 10; Tr. I at 241-242.

While each of the parties has presented compelling arguments in support of their respective positions, I am persuaded that the more appropriate approach is that offered by OHIC. In sum, the surplus generated from the premiums (amounting to approximately $6 million) as well as the federal adjustment to the percentage for significant claims ($4.9 million) shall be used to benefit Blue Cross' capital reserves. However, the recent federal adjustment to the percentage paid on high claims ($4.7 million) and the risk adjustment ($577,730) should be used as a dollar-for-dollar adjustment to the 2016 rates for the Direct Pay market. I also recommend a 3 percent contribution to reserves, in order to strengthen Blue Cross' financial footing.

With the $4.7 million applied in this manner, it is anticipated that it will reduce the 2016 EHB rate increase by approximately 3 percent. Tr. II at 185. With the additional $577,730 applied in this manner, it is expected to reduce the EHB rate increase by .2 to .3 percent. Tr. II at 186.

Rates for Health Plans With and Without Coverage for Abortion Services

Blue Cross requires subscribers who purchase a plan that covers abortion services to pay an additional $0.04 PMPM. Tr. II at 187. OHIC is opposed to the higher premium for plans that cover abortion services since Blue Cross has not provided evidence to support the extra premium from an actuarial perspective. Rather, Blue Cross has interpreted federal requirements to impose this additional fee. Tr. I at 166. I do not find support for Blue Cross' position under the federal law and regulations. As I explained in my Report and Recommendation last year, federal law prohibits the use of federal funds for abortion services consistent with a long-standing federal statutory restriction that is commonly known as the Hyde Amendment. 75 F.R. 15599 (March 24, 2010) (Executive Order). If a health insurance carrier provides coverage for abortion services, it must not use any amount attributable to either the credits afforded under the ACA or toward any cost-sharing reduction under the ACA. 45 C.F.R. 156.280(e)(1). Neither the ACA nor the regulations require any additional, separate premium. The federal law calls for a payment of the existing premium to be segregated for the purpose of providing abortion services. That separate payment cannot be made from federal subsidies. Since Blue Cross has not presented evidence to support the rate increase from an actuarial basis, I recommend that there be no separate premium for abortion services in the amount of $0.04 PMPM.

V. FINDINGS OF FACT

Based upon the evidence submitted, I hereby make the following proposed findings of fact with respect to the 2016 Direct Pay Filing:

1. The preceding sections I through IV of this Report and Recommendation are incorporated into these Findings of Fact.

2. Health Insurance Commissioner Kathleen C. Hittner, MD, appointed me to serve as her designee and to conduct this hearing, pursuant to R.I. Gen. Laws § 27-19-6(c)(d).

3. On May 15, 2015, Blue Cross submitted a Rate Filing for the Direct Pay market with the Health Insurance Commissioner seeking an overall average rate increase of 17.9 percent in the Essential Health Benefit ("EHB") rate to become effective January 1, 2016 (the "Filing").

4. On or about June 1, 2015, Blue Cross modified its Filing to remove the "Advance" product and add a new plan called "BlueChiP Direct." The modification resulted in a proposed EHB rate increase from 17.9 percent to 18 percent.

5. On June 24, 2015, OHIC issued a memorandum to insurance carriers indicating that "it does not intend to approve broker commissions in the Individual market for plans effective January 1, 2016." OHIC Ex. 7a; Tr. I at 31. Likewise, the General Assembly passed a budget that included a lower fee of 3.5 percent for the HealthSource RI Exchange ("HSRI"). The fee is now distributed across all of Blue Cross' Individual market members, not only those who obtained coverage from HSRI, resulting in an effective charge of 2.6 percent of premium.

6. Blue Cross submitted a modified Filing to reflect these changes, resulting in a weighted average rate increase from 11 percent to 7.3 percent and a reduction in the EHB rate increase from 18 percent to 14.2 percent. BC Ex. 3; Tr. I at 32.

7. Pursuant to a Scheduling Order entered on April 27, 2015, as amended on April 28 and May 15, 2015, this matter was scheduled for a rate hearing on July 7 and July 8, 2015. The rate hearing was recorded by a stenographer and was held in public session. The hearing was conducted in accordance with the Administrative Procedures Act, R.I. Gen. Laws § 42-35-1, *et seq.*

8. The Filing was advertised in accordance with applicable law and with the aforesaid Order, as amended, in the *Providence Journal* on June 24, 2015. The notice of the public hearing was also provided to all Blue Cross subscribers who are subject to the proposed rate increase. The notice was delivered by mail between June 19 and June 24, 2015, pursuant to R.I. Gen. Laws § 27-19-6(a) and § 27-20-6(a).

9. In accordance with R.I. Gen. Laws §§ 27-19-6, 27-206, 42-14.5-3(d), and 42-14-5(d), 42-62-13, 27-18.2-1 *et seq.*, 27-19-6 and 27-20-6, the Commissioner, through her designee, Hearing Officer Marcaccio, has jurisdiction in this proceeding to conduct the hearings for purposes of considering Blue Cross' Direct Pay Rate Request.

10. Members of the public submitted comments to OHIC and the Hearing Officer prior to the hearing through correspondence and emails. Members of the public likewise provided comments in person at the public hearings conducted on July 7 and 8, 2015. The public comments indicated that the current premiums are not affordable and additional increases will cause economic hardships.

11. The Attorney General submitted discovery in the form of data requests on May 20, June 1, June 2, June 5, June 8 and June 10, 2015.

12. OHIC submitted discovery to Blue Cross on May 22, June 1, June 4, June 11 and June 19, 2015.

13. An emergency hearing was conducted on June 9, 2015, via telephone to address Blue Cross' Motion for a Protective Order prohibiting the disclosure of Blue Cross meeting minutes to the designated experts of the Attorney General and OHIC. That motion was denied.

14. An emergency hearing was conducted on June 19, 2015, via telephone to address an Emergency Motion to Extend Time to File Alternative Calculations. That motion was denied.

15. An emergency hearing was initially conducted via telephone on June 30, 2105, to address a Motion to Intervene filed by Neighborhood Health Plan of Rhode Island. A subsequent hearing was held on July 1, 2015. A full hearing was conducted on said motion which was transcribed by a stenographer. As set forth in my July 2, 2015 Order, the motion was denied since Neighborhood Health had not met the criteria necessary to permit its intervention as a party and, further, the public interest was adequately represented by the Attorney General and OHIC.

16. At the commencement of the hearing on July 7, 2015, the parties stipulated that the notice of public hearing was properly published and mailed to all Direct Pay subscribers; that

the Hearing Officer and the Health Insurance Commissioner had jurisdiction to hear the Direct Pay matter; and that the actuarial experts for each of the parties are deemed to be experts in their field of actuarial science and were allowed to testify as such.

17. In support of its requested rate increase, Blue Cross submitted its Filing of May 15, 2015, as amended on June 1, 2015 (BC Ex. 1). Blue Cross also introduced Exhibit 2, an Affidavit of Notice of Tonya Hoegen providing proof and substance of the public notice, and Exhibit 3, a revised OHIC Template as of June 26, 2015. Thereafter, during the hearing, Blue Cross Exhibit 4 was ultimately accepted as a full exhibit over the objection of the Attorney General which consisted of a graph illustrating allowed PMPM by standardized month for 2015 between new Exchange members (January – May) and all other members.

18. In support of its opposition to Blue Cross' requested rate increase, the Attorney General submitted the report of Barbara Niehus, FSA, MAAA, along with her schedules supporting her calculations, AG Ex. A, with attachments AGBN-1 through AGBN-13; AG Exhibits B through AG-AR; and AG-AS, which consisted of Ms. Niehus' supplement to her report dated June 29, 2015.

19. In support of its opposition to Blue Cross' requested rate increase, OHIC submitted the actuarial analysis of Charles C. DeWeese, FSA, MAAA as well as their supporting Exhibits 2 – 46. At the hearing, Blue Cross also introduce for identification only Exhibit 47, an OHIC bulletin entitled "Renewal and Discontinuance of the Plans in the Individual and Small Group Markets."

20. The Filing is intended to comply with all of the Patient Protection and Affordable Care Act ("ACA") requirements for plans that will be sold be Blue Cross both through the Exchange and outside of the Exchange in the Individual market.

21. With each of the modifications submitted by Blue Cross to its original Filing of May 15, 2015, it is requesting an EHB rate of $376.84. BC Ex. 3, Rate Template Part II, Rate Development.

22. With respect to the lag factor adjustment proposed by Blue Cross, I find that the weight is considerably in favor of utilizing the claims data from all 12 months of 2014, rather than artificially excluding the first two months. It is customary to use every month of claims data when projecting future claims. Apparently, no other carrier employs this factor to exclude relevant data. Tr. I at 179. Blue Cross has not persuaded me to digress from that standard actuarial practice. According to the testimony of OHIC and the Attorney General, by removing Blue Cross' proposed lag factor adjustment, the EHB Rate increase will be reduced by either 1.5 percent or 1.6 percent.[6]

23. Blue Cross calculated a negative 4.5 percent trend, with a very reliable R-squared value of .933 for its in-patient hospital utilization. A negative 4.5 percent utilization trend simply is not sustainable in the long term. However, I find the evidence to establish that it is very reasonable to expect to see some negative trend continue in 2016. Tr. I at 229. I find that a negative 2 percent trend is more appropriate and I recommend its adoption. A reduction of the in-patient hospital utilization trend from 0 percent to negative 2 percent should result in a 0.8 percent or 0.9 percent decrease to the proposed EHB rate. AG Ex. A, AGBN-5; AG Ex. AS at 1; Tr. I at 216-228; OHIC Ex. 9.

24. The parties anticipate the conversion to a new method of classifying diagnoses and procedures at hospitals within the claim system. Tr. I at 102. Blue Cross attributes a 1

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[6] The estimated change to the EHB rate will be subject to the recalculations to be run by the parties based upon each of the adjustments required by the Commissioner's final Decision.

percent increase to its in-patient hospital costs, commencing in October of 2015, as a result of the new coding system. I am not persuaded that the proposed increase is justified. Blue Cross did not introduce any documentation that supports a finding that the conversion will increase costs. Given that CMS currently predicts a neutral impact in costs, and given the absence of sufficient evidence to the contrary, I find this aspect of the projected trend increase to be too speculative to support. The proposed increase to rates should be removed from the 2016 rate increase. I anticipate that that the EHB rate increase will be reduced by 0.2 percent. OHIC Ex. 9.

25. When calculating the hospital out-patient utilization trend, Blue Cross reduced the weight of the Small Group market by 50 percent when factoring in the results of each of the commercial business segments. I do not find sufficient evidence to justify Blue Cross' rejection of its own data and standard methodology. For each of the past three years, Blue Cross had projected this trend by measuring data from all three of its commercial markets. Simply because Blue Cross cannot immediately explain why the Small Group market yields a different trend, it is not a sufficient reason to diverge from its own standard actuarial practice. As such, I recommend that the trend observed for all three markets, 1.9 percent, be used to project the hospital out-patient utilization. This will reduce the EHB base rate increase by approximately 0.2 percent.

26. The professional services utilization trend measures the combined data for medical/surgical and primary care. Blue Cross' own methodology yielded a negative 1.6 percent trend for the entire commercial market with a very reliable .85 R-squared value. Tr. 1 at 231. Blue Cross adjusted its trend to a neutral 0 percent because it observed a positive utilization trend rate in 2014. Tr. I at 53. If any departure is warranted, as each party has suggested, I find that the most appropriate departure would recognize some negative trend, consistent with most of the statistical data. I therefore find that this category should utilize a negative 1 percent trend factor,

consistent with the recommendation of the Attorney General. This is expected to reduce the proposed EHB rate increase by 0.5 percent. AG Ex. A at 10, Attachment AGBN-7, AG Ex. AS at 2; Tr. I at 231-232.

27. The Blue Cross filing included a 9.5 percent trend factor for pharmacy. OHIC withdrew its opposition based upon the testimony at the hearing. I am equally persuaded by the statistical evidence, which demonstrates a best fit trend line yielding the 9.5 percent increase. Thus, I recommend that a 9.5 percent trend be used for the pharmacy component.

28. When projecting its 2016 claim costs, Blue Cross calculated a credit against claims attributable to the Federal Transitional Reinsurance program. I find that Blue Cross has not met its burden to establish why it should exclude utilization trends when calculating a credit against claims under the Federal Transitional Reinsurance program. I conclude that Blue Cross should apply the same trend factors – including utilization – when calculating projected federal reinsurance credits as it does for the remainder of its Filing. I anticipate that this will reduce the increase in the 2016 EHB rate by 0.2 percent.

29. The Filing includes an adjustment for uncollected premiums that occurred in 2014. Since Blue Cross made payment of all claims that occurred during the grace period, it is therefore appropriate to distribute that lost premium to all of its members when projecting its rates for 2016. I recommend the Blue Cross proposal of 0.9 percent of required premium for 2016 in anticipation of uncollected premiums during the grace period for 2016.

30. Blue Cross requests a 3 percent contribution to its capital reserves with this Filing. The contribution consists of a 2 percent contribution to reserves, .34 percent for the costs associated with a new claims processing system, and .5 percent to pay for any federal taxes on the reserve contribution, for a total of 2.84 percent. Blue Cross rounds this figure up to a 3

percent contribution. In order to ensure the financial stability of Blue Cross, I recommend that the request for a 3 percent contribution to reserves be permitted.

31. In June of 2015, the federal government announced that it would increase the percentage of reimbursement to carriers, from 80 percent to a full 100 percent on claims paid between $45,000 and $250,000. Tr. I at 34-36. This will likely result in the receipt to Blue Cross of an additional $4.7 million for the 2014 rate year.

32. Also in June of 2015, the federal government notified Blue Cross that it would receive a payment through the Federal Risk Adjustment program in the amount of approximately $577,730.

33. I recommend that the additional monies received from the Federal Transitional Reinsurance program ($4.7 million) as well as the Federal Risk Adjustment subsidy ($577,730) be applied on a dollar-for-dollar basis in order to reduce the 2016 rates for the Direct Pay market. With the $4.7 million applied in this manner, it is anticipated that it will reduce the 2016 EHB rate increase by approximately 3 percent. Tr. II at 185. With the additional $577,730 applied in this manner, it is expected to reduce the EHB rate increase by .2 to .3 percent. Tr. II at 186.

34. I recommend that Blue Cross not be permitted to charge an additional premium of $0.04 PMPM to subscribers of plans that provide abortion services. Blue Cross has not presented any evidence to support the extra premium from an actuarial perspective.

VI. CONCLUSIONS OF LAW

1. The preceding Sections I through V of this Report and Recommendation are incorporated herein into these Conclusions of Law.

2. OHIC has jurisdiction to hear and decide this matter pursuant to R.I. Gen. Laws §§ 42-14.5-3(d), 42-14-5(d), 27-18.5-1 *et seq.*, 27-19-6 and 27-20-6.

3. This hearing was conducted in compliance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*

4. All of the procedural prerequisites for the conduct of the hearing have been followed.

5. In accordance with applicable statutes, OHIC has the jurisdiction and authority to determine whether or not the proposed rates for the Direct Pay plans satisfy each of the legal mandates, including the requirement that Blue Cross provide rates that are affordable and also provide access to healthcare coverage. R.I. Gen. Laws §§ 27-19.2-3(1) and (5).

6. Blue Cross is statutorily required to "employ pricing strategies that enhance the affordability of healthcare coverage" and is also required to protect its financial condition. R.I. Gen. Laws § 27-19.2-10(3) and (4).

7. In accordance with the applicable statutes, OHIC is authorized to accept, reject, or modify the proposed rates submitted by Blue Cross in accordance with R.I. Gen. Laws §§ 27-19-6 and 27-20-6.

8. Blue Cross' Direct Pay Rate Filing for 2016 is also governed by the implementation of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. 111-148, 124 Stat. 119.

9. The Commissioner, through her designee, Raymond A. Marcaccio, Esquire, has jurisdiction in this proceeding to conduct the hearings for purpose of considering whether Blue Cross' proposals contained in its Filing of May 15, 2015, as amended, are consistent with the proper conduct of Blue Cross' business and also in the interest of the public. R.I. Gen. Laws §§ 27-19-1 *et seq.*, 27-20-1 *et seq.*, 42-14.5-1 *et seq.*, and 42-14-1 *et seq.*

10. Blue Cross has the burden of proof to establish that the proposed rates are consistent with the statutory requirements set forth above. This burden is met by a preponderance of the evidence.

11. Blue Cross has not satisfied its burden of proving that the modified proposed rate increase of 14.2 percent to the EHB rate is consistent with the proper conduct of its business and also in the interest of providing affordable health insurance coverage to the public.

12. An adjustment to the overall rate increase and EHB rate shall be calculated in accordance with the final Decision of the Commissioner.

13. Any Finding of Fact that is also a Conclusion of Law is hereby adopted as a Conclusion of Law.

Respectfully submitted to Commissioner Kathleen C. Hittner, M.D., this 27th day of July, 2015.

Raymond A. Marcaccio, Hearing Officer